and record in the survey record, that the facility has made substantial progress in meeting its plan for correction. These findings must be based on onsite surveys by qualified surveyors. The survey agency must support these findings by placing signed contracts, work orders, or other documents in the survey record.

(f) *State fire safety and sanitation requirements.* The survey agency must find that, during the period allowed for corrections, the facility meets State fire safety and sanitation codes and regulations.

[43 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993, Jan. 25, 1988]

§ 442.112 Extended period for correcting deficiencies: ICFs/MR: Life Safety Code and living/dining/therapy area deficiencies.

(a) *Scope.* This section applies to ICF's/MR that are deficient in meeting requirements for—

(1) Life Safety Code (§§ 442.507-442.509);

(2) Living units (§§ 442.447(a) (1), (2), (4), (5), (b), (c), 442.448(d), 442.449 (a), (b), 442.450(a)(2), 442.451(a), 442.452, 442.453);

(3) Dining rooms (§ 442.471(a)-(c)); or

(4) Therapy areas (§ 442.488(e)).

(b) *Certification period.* The survey agency may certify an ICF/MR under § 442.105 for up to 12 months even though the deficiencies listed in paragraph (a) of this section may take more than 12 months to correct, if the conditions in this section and § 442.115 are met.

(c) *Written plan for correction.* Before certifying an ICF/MR under this section, the survey agency must approve, in writing, the ICF/MR's written plan for correcting those deficiencies. The plan must—

(1) State the extent to which the ICF/MR complies with the requirements it does not fully meet;

(2) Specify the steps the ICF/MR will take to correct the deficiencies;

(3) Specify a timetable for taking each of those steps and a date for completion of corrections;

(4) For a public ICF/MR, be approved by the State or political subdivision that has jurisdiction over its operation (A public facility is defined in § 435.1009 of this subchapter as one that is the "responsibility of a governmental unit or over which a governmental unit exercises administrative control."); and

(5) Meet the conditions of § 442.113.

(d) *Progress in meeting correction plan.* Within each 6-month period after initial approval of the plan, the survey agency must find, and record in the survey record, that the ICF/MR has made substantial progress in meeting the plan for correction. These findings must be based on onsite surveys by qualified surveyors. The survey agency must support these findings by placing signed contracts, work orders, or other documentation in the survey record.

(e) *State fire safety and sanitation requirements.* The survey agency must find that, during the period allowed for corrections, the ICF/MR meets the State fire safety and sanitation codes and regulations.

[43 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993 and 1994, Jan. 25, 1988]

§ 442.113 Correction plans for ICFs/MR: Life Safety Code and living/dining/therapy area deficiencies.

(a) The ICF/MR's plan required by § 442.112 must provide for completion of corrections by:

(1) July 18, 1980; or

(2) July 18, 1982, if authorized by HCFA under paragraph (b) or (e) of this section; or

(3) the date approved by HCFA, if authorized by HCFA under paragraph (f) of this section; or

(4) the date approved by HCFA, if authorized by HCFA under paragraph (g) of this section, when corrections of deficiencies in units to be retained are completed within the appropriate time period as set forth in paragraph (g) of this section.

(b) If, at the time of the first survey of the ICF/MR after July 17, 1977, it is unable to develop a plan to complete corrections by July 18, 1980, the survey agency may request HCFA to authorize approval of a plan to complete them by July 18, 1982. HCFA will authorize this approval for each

deficiency if it is determined that time beyond July 18, 1977, is needed—

(1) As a practical matter to complete the corrections;

(2) To prevent unreasonable hardship to the ICF/MR; and

(3) To insure continued care for recipients served by the ICF/MR.

(c) If the plan provides for correction through structural change or renovation, it must—

(1) Contain a timetable showing the corrective steps and their completion dates;

(2) Specify the structural change or renovation; and

(3) Document that sufficient financial resources are available to complete the change or renovation on schedule.

(d) If the plan provides for correction by phasing out part or all of the ICF/MR, it must—

(1) Contain a timetable showing the buildings or units to be closed and describing the steps for phasing them out;

(2) Describe the methods that insure the recipients' health and safety until the building or unit is closed; and

(3) Provide that no new recipients will be admitted to the building or unit after the plan has been approved.

(e) If an ICF/MR is unable to complete corrections required by the plan of correction by July 18, 1980 and it did not request an extension beyond that date under paragraph (b) of this section, the survey agency may request HCFA to authorize approval for an extension of the facility's plan of correction to July 18, 1982 if—

(1) For corrections under paragraph (c) of this section, the facility provides documentation from the renovation project's supervising architect or contractor that required construction work was at least 25 percent completed by July 18, 1980 and will be completed by July 18, 1982;

(2) For corrections under paragraph (d) of this section, the facility provides documentation that the phase out program was at least 25 percent completed on July 18, 1980 and will be completed by July 18, 1982; and

(3) The survey agency finds that all continuing deficiencies covered by the plan of correction will be resolved by completion of the construction, renovation, or phase out of beds.

(f) If an ICF/MR is unable to complete corrections required by the plan of correction by July 18, 1980 or July 18, 1982, as authorized in paragraphs (a), (b) and (e) of this section, the survey agency may request HCFA to authorize a plan of correction for an additional period of time if the delay was caused by litigation, provided that—

(1) The United States, or any agency or Department thereof, was party to the litigation, or was an intervenor in it, or participated as an *amicus curiae*; and

(2) The United States advocated a position which caused or contributed, in whole or in part, to the delay; and

(3) The request for an additional period of time to complete corrections under this provision does not exceed the amount of the delay resulting from the litigation, as determined by HCFA.

(g) The survey agency may request HCFA by November 24, 1982 to approve a revision to the existing correction plan of an ICF/MR under this section if the facility chooses to engage in a partial or complete phase out of beds in certified units of the facility already contained in the present correction plan as follows:

(1) The extended phase out period to be approved by HCFA may be 1 to 5 years from August 26, 1982 if the facility:

(i) Provides documentation that it has completed at least 25 percent of the items in the original correction plans under paragraphs (c) and (d) of this section;

(ii) Increases the total number of beds being phased out within certified units;

(iii) Agrees to a rate of decline in resident population, and establishes, in the revised correction plan submitted under this paragraph, targets at six-month intervals for the phasing out of a specific number of beds;

(iv) Assures the health and safety of the residents until the buildings or units are phased out; and

(v) Ensures that only residents who are classified for the ICF/MR level of care when the revised correction plan

submitted under this paragraph is approved, will be admitted thereafter to the buildings or units being phased out.

(2) The survey agency must ensure that the facility has met all the facility standards for ICFs/MR (Subpart G of this part), or has an approved plan of correction for those certified buildings and units in use and to be retained after the phase out plan is completed; and

(3) The facility may not seek certification of units not currently certified in order to add the beds in those units to an expanded phase out plan as a means of taking advantage of this regulation.

(4) FFP will not be available for costs attributable to any beds which remain above the targeted phase out goals after each 6-month target date is passed.

(Secs. 1102, 1905(c) and 1905(d) of the Social Security Act (42 U.S.C. 1302, 1396d(c), 1396(d))

[47 FR 37549, Aug. 26, 1982. Redesignated and amended at 53 FR 1993 and 1994, Jan. 25, 1988]

§ 442.114 Correction and reduction plans for ICFs/MR: General provisions.

(a) *Options of Medicaid agency.* If HCFA finds substantial deficiencies only in physical plant and staffing that do not pose an immediate threat to the clients' health and safety in an ICF/MR, HCFA will forward the list of deficiencies to the Medicaid agency and the agency may elect to—

(1) Submit to HCFA within 30 days of receipt of the list of deficiencies a written plan of correction in accordance with § 442.115, as permitted by § 442.105; or

(2) Submit to HCFA within 65 days of receipt of the list of deficiencies a written plan to reduce permanently the number of beds in certified units in accordance with § 442.116. The purpose of the reduction plan is to vacate any noncomplying buildings (or distinct parts thereof) and correct any staff deficiencies within 36 months of the approval of the plan.

(b) *Option limitation for Medicaid agency.* An ICF/MR found to have substantial deficiencies in physical plant and staffing, and substantial deficiencies in other areas of care is not eligible for either a correction or reduction plan under this section.

(c) *HCFA options.* (1) If the Medicaid agency does not comply with paragraph (a) of this section, HCFA may cancel approval of the deficient ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) HCFA will respond in writing to the agency within 30 days from receipt of a proposed correction plan submitted under paragraph (a)(1) of this section.

(d) *Duration.* The provisions of this section and §§ 442.115 and 442.116 apply only to correction and reduction plans approved by HCFA within 3 years after Federal surveys initiated in ICF/MRs on or after April 7, 1986.

[53 FR 1994, Jan. 25, 1988]

§ 442.115 Correction plans for ICFs/MR: Specific requirements.

(a) *Contents.* A correction plan under § 442.114(a)(1) must include—

(1) An explanation of the extent to which the ICF/MR currently complies with the standards for ICFs/MR in Subpart G including all deficiencies identified during a direct Federal survey, and

(2) A timetable for completing the necessary steps to correct staff and physical plant deficiencies on which the request for a correction plan is based, and all other minor deficiencies, within 6 months of the approval date of the plan.

(b) *HCFA policies.* HCFA considers a correction plan only if HCFA received it within 30 days of receipt by the Medicaid agency of the list of deficiencies referred to in § 442.114(a). After consideration of the plan, HCFA will forward in writing its approval or disapproval within 30 days of receipt of the proposed correction plan.

(c) *Exception.* If, as a result of a public hearing, the Medicaid agency decides that a reduction plan is not appropriate, and instead decides to submit a correction plan, the correction plan must be received by HCFA within 30 days from the date of the public hearing.

(d) *Termination of an ICF/MR.* (1) If the Medicaid agency submits a correction plan that HCFA finds to be unacceptable, HCFA will notify the agency of its disapproval and will terminate the ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) If, at the conclusion of the 6-month period specified in the plan of correction described in paragraph (a) of this section, HCFA determines that the agency has substantially failed to correct the deficiencies identified, HCFA may terminate the ICF/MR from participating in the Medicaid program in accordance with section 1910(c) of the Act.

[53 FR 1994, Jan. 25, 1988]

§ 442.116 Reduction plans for ICFs/MR: Specific requirements.

(a) *Conditions of approval: Agency requirements.* Before submitting a reduction plan under § 442.114(a)(2) to HCFA, the Medicaid agency must—

(1) Conduct a public hearing at the affected ICF/MR at least 35 days before submitting the reduction plan to HCFA that outlines the—

(i) Contents of the reduction plan,

(ii) Process for submitting the plan to HCFA, and

(iii) Process for submitting public comments to HCFA within 30 days of receipt of the reduction plan by HCFA.

(2) Provide written notice of the hearing to staff, clients and their parents or guardians, and the nearest, most interested, or involved family member or party, as appropriate, at least 10 days prior to the hearing date.

(3) Announce to advocacy and other interested groups and agencies; the courts with which the ICF/MR is involved in litigation (if any) arising out of its Medicaid participation; and the general community; through local media notices, at least 10 days prior to the hearing date—

(i) The exact date, time and location of the hearing; and

(ii) The locations (that is, the affected ICF/MR, the State mental retardation administration, State survey agency, State Developmental Disabilities Council, State and local protection and advocacy agencies and other agencies, which in the State's judgment, serve potentially interested parties (for example, State and local associations for retarded citizens)) where the proposed plan is displayed.

(4) Demonstrate that it has successfully provided home and community services similar to those services proposed to be provided under the reduction plan for similar individuals eligible for Medicaid by including—

(i) Documentation of existing programs and level of funding, and

(ii) Projections for growth and how the growth will be funded to accommodate the clients being displaced by the reduction plan.

(5) Provide assurances to HCFA that the reduction plan will be completed by fulfilling the content requirements of the reduction plan contained in paragraph (d) of this section.

(b) *Withdrawal by a Medicaid agency of a proposed reduction plan.* If, after the public hearing, a Medicaid agency decides a reduction plan would not be appropriate, the agency may choose to proceed with a plan of correction in accordance with the requirements contained in §§ 442.115 (a) and (c).

(c) *Submittal date of plan.* On the day that the Medicaid agency submits a reduction plan, the agency must announce through local media notices—

(1) That the plan has been submitted to HCFA;

(2) That the plan is on display at the affected ICF/MR, the State mental retardation administration, State survey agency, State Developmental Disabilities Council, State and local protection and advocacy agencies, and other agencies, which in the State's judgment, serve potentially interested parties (for example, State and local associations for retarded citizens); and

(3) The address of the appropriate HCFA office for forwarding comments on the reduction plan and the closing date for receipt of those comments.

(d) *Contents.* A reduction plan must—

(1) Identify the number of clients and their service needs on a client-by-client basis for home or community services, and a timetable for providing such services, in 6-month intervals, within the 36-month period beginning

on the date that the reduction plan is approved by HCFA:

(2) Describe the methods used to—

(i) Select clients for home or community services, and

(ii) Develop alternative home and community services to effectively meet the clients' needs;

(3) Describe the safeguards that will be applied to protect the clients' health and welfare while receiving home or community services, including—

(i) Adequate standards for participation by clients, clients' families and providers; and

(ii) Assurances that the community residences in which the affected clients are placed meet all applicable State and Federal licensure and certification requirements;

(4) Provide that clients who are eligible for medical assistance while in the ICF/MR will, at their option, be placed in another setting (or another part of the ICF/MR) so as to retain their eligibility for medical assistance.

(5) Specify the actions to protect the health and safety of the clients remaining in the ICF/MR while the reduction plan is in effect;

(6) Provide that the staff-to-client ratio at the ICF/MR will be the higher of—

(i) The ratio described in the standards for ICFs and ICFs/MR (§ 442.445); or

(ii) The ratio which was in effect at the time the direct Federal survey was conducted; and

(7) Provide for the protection of the staff affected by the reduction plan, including—

(i) Arrangements to preserve staff rights and benefits;

(ii) Training and retraining of staff where necessary;

(iii) Redeploying staff to community settings under the reduction plan; and

(iv) Making maximum efforts to secure employment (without necessarily guaranteeing the employment of any staff).

(e) *HCFA policies.* (1) HCFA will consider approval of reduction plans on a first come, first served basis. HCFA will provide the public at least 30 days after the Medicaid agency submits a reduction plan to comment on the proposed plan. After the close of the public comment period, HCFA will forward in writing its approval or disapproval of the reduction plan to the agency within 30 days.

(2) If HCFA approves more than 15 reduction plans in any fiscal year, any reduction plans approved in addition to the first 15 approved plans, will be for an ICF/MR (or distinct part thereof) for which the costs of correcting the substantial deficiencies are $2 million or greater (as demonstrated by the Medicaid agency to the satisfaction of HCFA).

(3) HCFA may approve reduction plans for a shorter period than 36 months, where applicable.

(4) HCFA approval of a reduction plan does not constitute approval of any request for a home and community-based waiver. Home and community-based waivers are subject to HCFA review and approval under § 441.300 of this chapter. Disapproval of a request for a home and community-based waiver constitutes disapproval of a request for a reduction plan that is dependent upon approval of the request for a home and community-based waiver.

(f) *Termination of an ICF/MR.* (1) If the Medicaid agency submits a reduction plan that HCFA finds to be unacceptable, HCFA will notify the agency of its disapproval and terminate the ICF/MR's participation in the Medicaid program in accordance with section 1910(c) of the Act.

(2) If, at the conclusion of the initial 6-month period or any 6-month interval thereafter of the reduction plan, HCFA determines that the Medicaid agency has substantially failed to meet the requirements of paragraph (a) of this section, HCFA will—

(i) Terminate the ICF/MR from participating in the Medicaid program in accordance with section 1910(c) of the Act, or

(ii) Disallow FFP equal to 5 percent of the cost of care for all eligible clients for each month for which the agency failed to meet the requirements despite good faith efforts it may have made.

[53 FR 1994, Jan. 25, 1988]

**§ 442.117 Termination of certification for facilities whose deficiencies pose immediate jeopardy.**

(a) A survey agency must terminate a facility's certification if it determines that—

(1) The facility no longer meets applicable conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) specified under Subpart D, E, and F of this part or Part 483, Subpart D of this chapter; and

(2) The facility's deficiencies pose immediate jeopardy to patients' health and safety.

(b) Subsequent to a certification of a facility's noncompliance, the Medicaid agency must, in terminating the provider agreement, follow the appeals process specified in Part 431, Subpart D of this chapter.

[51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988]

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3, 1988, in § 442.117, paragraph (a) (1) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

**§ 442.117 Termination of certification for facilities whose deficiencies pose immediate jeopardy.**

(a) * * *

(1) The facility no longer meets applicable conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR) specified under Subpart D, E, F, or G of this part, and

* * * * *

**§ 442.118 Denial of payments for new admissions.**

(a) *Basis for denial of payments.* The Medicaid agency may deny payment for new admissions to a SNF, ICF, or ICF/MR that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR) specified under Subpart D, E, F, or G of this part if either of the following conditions is met:

(1) *Facility's deficiencies do not pose immediate jeopardy.* If the agency finds that the facility's deficiencies do not pose immediate jeopardy to patients health and safety, the agency may either terminate the facility's provider agreement or deny payment for new admissions.

(2) *Facility's deficiencies do pose immediate jeopardy.* If the agency finds that the facility's deficiencies do pose immediate jeopardy to patients' health and safety and thereby terminates the facility's provider agreement, the agency may additionally seek to impose the denial of payment sanction.

(b) *Agency procedures.* Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with the conditions (for SNFs and ICFs/MR) or the standards (for ICFs).

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the applicable conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) participation; and

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

(c) *Effect of denial of Medicare payment*—(1) *Period of denial.* If HCFA denies Medicare payments for new admissions to a SNF that also participates in Medicaid, the Medicaid agency must deny Medicaid payments for new admissions, effective for the same time period that Medicare payments are denied.

(2) *Informal hearing.* Only one informal hearing is available to a SNF that participates in both programs. It would be provided by HCFA in accordance with § 489.62(c) of this chapter.

[51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988]

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3, 1988, § 442.118 (b)(1) and (b)(3)(i) was amended, effective October 3, 1988. Paragraph (b)(1) was amended by adding the phrase "ICFs/MR" after "SNFs", and paragraph (b)(3)(i) was amended by removing the phrase "conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR)" and adding in its place the phrase "conditions of participation (for SNFs and ICFs/MR or standards (for ICFs)."

**§ 442.119 Duration of denial of payments and subsequent termination.**

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs); or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs) during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in Subpart D of Part 431 of this chapter.

[51 FR 24491, July 3, 1986, as amended at 53 FR 20496, June 3, 1988]

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3, 1988, § 442.118(a)(1) and (b)(1) were amended by removing the phrase "conditions of participation (for SNFs) or standards (for ICFs and ICFs/MR)" and adding in its place the phrase "conditions of participation (for SNFs and ICFs/MR) or standards (for ICFs)", effective October 3, 1988.

## Subpart E—Intermediate Care Facility Requirements; All Facilities

### § 442.250 Purpose.

This subpart specifies the requirements that an ICF must meet to obtain certification from the State survey agency as a qualified provider of ICF services.

### § 442.251 State licensing standards.

(a) Except as provided in paragraph (b) of this section, an ICF must meet standards for a State license to provide, on a regular basis, health-related care and services to individuals who do not require hospital or SNF care, but whose mental or physical condition requires services—

(1) Above the level of room and board; and

(2) That can be provided only by an institution.

(b) An ICF that formerly met State licensing standards but does not currently meet them may continue to receive Medicaid payments as a qualified provider during a period specified by the State authority responsible for licensing the facility if, during that period, the ICF takes the steps needed to again meet the standards.

(c) An ICF operated by a government agency must meet the licensing standards that apply to the same type of facility operated under any other ownership.

(d) In accordance with § 431.110 of this subchapter, an Indian Health Service ICF must meet State licensing standards although it need not obtain a license. In making this determination, the licensing authority may not take into account an absence of licensure of any staff member of the facility.

### § 442.252 State safety and sanitation standards.

An ICF must meet State safety and sanitation standards for nursing homes.

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3, 1988, § 442.252 was removed, effective Oct. 3, 1988.

### § 442.253 Federal definition and standards.

(a) An ICF other than an ICF/MR must meet the definition in § 440.150 of this subchapter and the standards specified in this subpart and Subpart F of this part, except for provisions waived or accepted under plans of corrections as specified in Subpart C of this part.

(b) An ICF/MR must meet the definition in § 440.150 of this subchapter and the standards specified in this subpart and Subpart G of this part, except for provisions waived or accepted under plans of correction as specified in Subpart C of this part.

### § 442.254 Standards for hospitals and SNF's providing ICF services.

(a) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF services other than ICF/MR services, it must meet the following ICF standards:

(1) Section 442.304, resident services director.

(2) Section 442.317 (a), (b), agreements with outside resources for institutional services.

(3) Section 442.319, plan of care.

(4) Section 442.320, resident financial records.

(5) Section 442.324 (b), handrails.

(6) Section 442.338 through 442.342, health services.

(7) Section 442.343, rehabilitative services.

(8) Section 442.344, social services.

(9) Section 442.345, activities program.

(10) Section 442.346, physician services.

(b) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF/MR services, it must meet each of the conditions of participation specified in Part 483, Subpart D of this chapter.

[43 FR 45233, Sept. 29, 1978, as amended at 53 FR 20496, June 3, 1988]

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3 1988, § 442.254 (b) was revised, effective October 3, 1988. For the convenience of the user, the superseded text is set forth below:

### § 442.254 Standards for hospitals and SNF's providing ICF services.

* * * * * *

(b) If a hospital or SNF participating in Medicare or Medicaid is also a provider of ICF/MR services, it must meet the standards in Subpart G of this part.

## PART 483—CONDITIONS OF PARTICIPATION FOR LONG TERM CARE FACILITIES

Subpart A-C—[Reserved]

Subpart D—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

Sec.
483.400 Basis and purpose.
483.405 Relationship to other HHS regulations.
483.410 Condition of participation: Governing body and management.
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483.450 Condition of participation: Client behavior and facility practices.
483.460 Condition of participation: Health care services.
483.470 Condition of participation: Physical environment.
483.480 Condition of participation: Dietetic services.

AUTHORITY: Secs. 1102, 1905(c) and (d) of the Social Security Act (42 U.S.C 1302, 1396d(c) and (d)).

SOURCE: 53 FR 20496, June 3, 1988, unless otherwise noted.

EFFECTIVE DATE NOTE: At 53 FR 20496, June 3, 1988, Part 483 was added, effective October 3, 1988.

Subpart A-C—[Reserved]

### Subpart D—Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded

#### § 483.400 Basis and purpose.

This subpart implements section 1905 (c) and (d) of the Act which gives the Secretary authority to prescribe regulations for intermediate care facility services in facilities for the mentally retarded or persons with related conditions.

#### § 483.405 Relationship to other HHS regulations.

In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR Part 80), nondiscrimination on the basis of handicap (45 CFR Part 84), nondiscrimination on the basis of age (45 CFR Part 91), protection of human subjects of research (45 CFR Part 46), and fraud and abuse (42 CFR Part 455). Although those regulations are not in themselves considered conditions of participation under this Part, their violation may result in the termination or suspension of, or the refusal to grant or continue, Federal financial assistance.

#### § 483.410 Condition of participation: Governing body and management.

(a) *Standard: Governing body.* The facility must identify an individual or individuals to constitute the governing body of the facility. The governing body must—

(1) Exercise general policy, budget, and operating direction over the facility;

(2) Set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility; and

(3) Appoint the administrator of the facility.

(b) *Standard: Compliance with Federal, State, and local laws.* The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health, safety, and sanitation.

(c) *Standard: Client records.*

(1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client and that documents the client's health care, active treatment, social information, and protection of the client's rights.

(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

(d) *Standard: Services provided under agreements with outside sources.*

(1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement must—

(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.

(3) The facility must assure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in § 483.470 (a) through (g), (j) and (k).

#### § 483.420 Condition of participation: Client protections.

(a) *Standard: Protection of clients' rights.* The facility must ensure the rights of all clients. Therefore, the facility must—

(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of

the United States, including the right to file complaints, and the right to due process;

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs;

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail;

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in his or her own clothing each day; and

(13) Permit a husband and wife who both reside in the facility to share a room.

(b) *Standard: Client finances.* (1) The facility must establish and maintain a system that—

(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

(c) *Standard: Communication with clients, parents, and guardians.* The facility must—

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

(2) Answer communications from clients' families and friends promptly and appropriately;

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

(d) *Standard: Staff treatment of clients.* (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility must ensure that all allegations of mistreatment, neglect or